Overview of Hypertension Guidelines for Bermuda

CLASSIFICATION AND DIAGNOSIS OF HYPERTENSION

Classification of Hypertension and Recommendations for Follow-up

Category	Systolic	Diastolic	Follow-up recommended to determine diagnosis without acute end organ-damage
Optimal BP	<120	<80	Recheck in two years
Normal BP	120 – 129	80 - 84	Recheck in two years
Pre-Hypertensive	**130 – 139**	**85 – 89**	Recheck in one year*
Stage 1 hypertension (mild)	140 – 159	90 – 99	Confirm within two months If still stage 1 and no other risk factors prescribe lifestyle modification and sodium restriction for 6 months. If other risk factors present treat
Stage 2 hypertension (moderate)	160 – 179	100 – 109	Evaluate, treat, or refer to source of care within one month
Stage 3 hypertension (severe)	≥180	≥110	Evaluate and treat immediately or within one week depending on clinical situation and complications
Isolated systolic hypertension 1	≥140	<90	Confirm within two months
Isolated systolic hypertension 2	≥160	<90	Evaluate and treat immediately or within one week depending on clinical situation and complications

Adapted: Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. 2004.

Pre-hypertension is not a disease category, but identifies individuals at **high risk** of developing hypertension.
* Provide lifestyle modification.
If systolic and diastolic categories are different, follow recommendations for the shorter time follow-up (e.g. 160/86 mm Hg should be evaluated or referred to source of care within one month).

MANAGEMENT OF HYPERTENSION

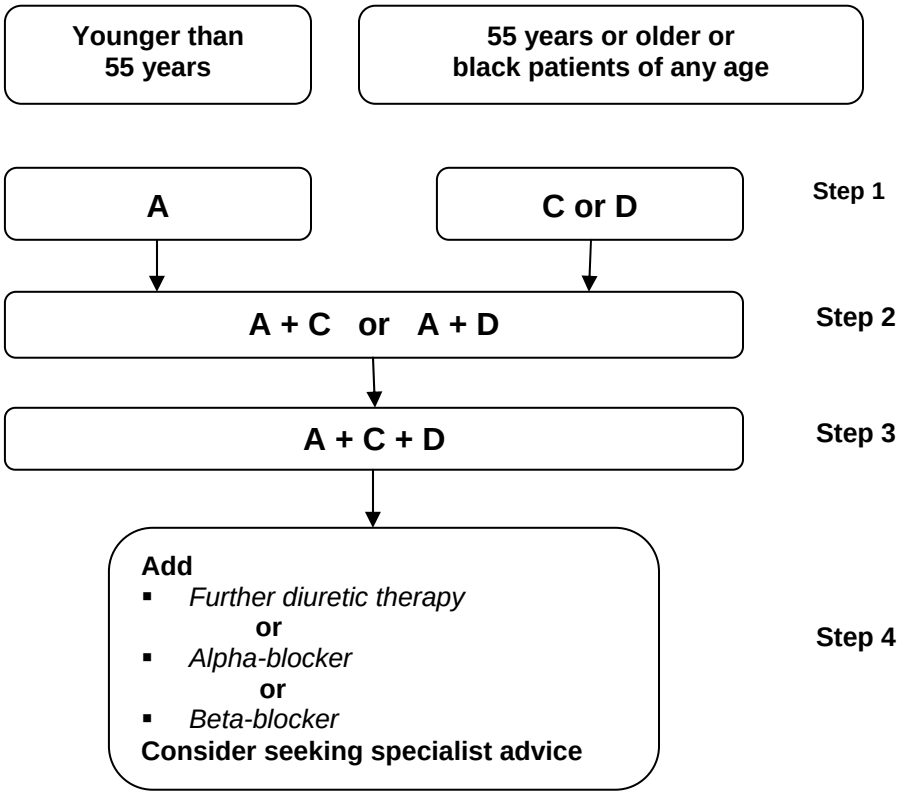
Monitoring Schedule for Management of Hypertensive Patients

Blood pressure level	Monitoring interval
BP<140/90	Reassess in 3-6 months
BP 140-159/90-99 (Stage 1)	Reassess within 2 months
BP 160-179/100-109 (Stage 2)	Treat, reassess or refer within 1 month
BP>180/110 (Stage 3)	Treat, reassess or refer within 7 days as necessary
BP>220/120	Treat immediately and reassess within 1-3 days as necessary
Malignant hypertensive or emergency patients	Refer for in-hospital treatment immediately
Isolated systolic hypertension (SBP>140, DBP<90)	As for category corresponding to SBP
Isolated systolic hypertension (SBP>160, DBP<90)	As for BP>180/110

Adapted from the following Guidelines: 1. *National Heart Foundation of Australia (National Blood Pressure and Vascular Disease Advisory Committee).Guide to Management of Hypertension 2008 AND*
2. *US Department of Health and Human Services Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. 2004 AND*
3. *Caribbean Health Research Council: Managing Hypertension in primary care in the Caribbean. St. Augustine, Trinidad and Tobago: Caribbean Health Research Council 2007*

ALGORITHM:
CHOOSING DRUGS FOR PATIENTS NEWLY DIAGNOSED WITH HYPERTENSION

Abbreviations:
A = ACE Inhibitor (consider angiotension-II receptor if ACE intolerant)
C = calcium-channel blocker
D = thiazide-type diuretic



Black patients are those of African descent, and NOT mixed-race, Asian or Chinese patients

Beta-blockers

- Beta-blockers are no longer preferred as a routine initial therapy for hypertension.
- But consider them for younger people, particularly:
  - Women of childbearing potential
  - Patients with evidence of increased sympathetic drive
  - Patients with intolerance of or contraindications to ACE inhibitors and angiotension-II receptor antagonists.
- If a patient taking a beta-blocker needs a second drug, add a calcium-channel blocker rather than a thiazide-type diuretic, to reduce the patient's risk of developing diabetes.
- If a patient's blood pressure is not controlled by a regime that includes a beta-blocker (that is, it is still above 140/90 mmHg), change their treatment by following the flow chart above.
- If a patient's blood pressure is well controlled (that is,140/90 mmHg) by a regime that includes a beta-blocker, consider long-term management at their routine review. There is no absolute need to replace the beta-blocker in this case.
- When withdrawing a beta-blocker, step down the dose gradually.
- Beta-blockers should not usually be withdrawn if a patient has a compelling indication for being treated with one, such as symptomatic angina or a previous myocardial infarction.

Source: NHS, National Institute for Health and Clinical Excellence: NICE clinical guideline 34: Hypertension: The management of hypertension in adults in primary care. London: Royal College of Physicians, 2008[6]